

MINNESOTA DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-028112

FILED VS AUG 31 1959

STATE FILE NUMBER

Registration District No. 30 Primary Registration District No. 5105 Registrar's No. 31

| | | | | | | | | | | |
|--|--|---|--|---|--|--|--|---|---------|--|
| 1. PLACE OF DEATH a. COUNTY <u>Benton</u> | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>CAMDEN</u> | | | | | | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Union Township</u> | | Length of stay in 1b <u>2 weeks.</u> | | c. CITY OR TOWN <u>CLIMAX SPRINGS</u> | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | | | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>7 miles S & E of Edwards</u> | | | Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | | d. STREET ADDRESS (If outside, give location) <u></u> | | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | | |
| 3. NAME OF DECEASED (Type or print) <u>William Louis Wiseman</u> | | | | First <u>William</u> Middle <u>Louis</u> Last <u>Wiseman</u> | | 4. DATE OF DEATH Month <u>Aug</u> Day <u>23</u> Year <u>1959</u> | | | | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>White</u> | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/> | | 8. DATE OF BIRTH <u>Oct 25, 1875</u> | 9. AGE (last birthday) <u>83</u> | IF UNDER 1 YEAR Months <u>9</u> Days <u>28</u> | | IF UNDER 24 HR Hours <u></u> Min. <u></u> | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farming</u> | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Retired Farm Owner</u> | | 11. BIRTHPLACE (City and state or country) <u>Benton Co. Mo</u> | | 12. CITIZEN OF WHAT COUNTRY <u>U. S. A</u> | | | |
| 13a. FATHER'S NAME <u>Perry A. Wiseman</u> | | | 13b. MOTHER'S MAIDEN NAME <u>Mary Ann Letha Douglas</u> | | | 14. NAME OF HUSBAND OR WIFE <u>Deceased</u> | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u> | | | 16. SOCIAL SECURITY NO. <u>No</u> | | 17. INFORMANT <u>Roscoe Wiseman Edwards Rt 1 Mo</u> | | | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchial Pneumonia</u> | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u> | | |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Senility</u> | | | | | | | | | | |
| DUE TO (c) <u></u> | | | | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) | | | | | | PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20a. ACCIDENT <input type="checkbox"/> | SUICIDE <input type="checkbox"/> | HOMICIDE <input type="checkbox"/> | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) | | | | | | |
| 20c. TIME OF INJURY Hour <u></u> Month, Day, Year <u></u> a.m. <u></u> p.m. <u></u> | | | | | | | | | | |
| 20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 20f. CITY, TOWN, OR LOCATION | | COUNTY | | STATE | | |
| 21. I attended the deceased from <u>1947</u> to <u>August 23, 1959</u> and last saw her/him alive on <u>August 22, 1959</u> Death occurred at <u>8:15 A. m</u> on the date stated above, and to the best of my knowledge, from the causes stated. | | | | | | | | | | |
| 22a. SIGNATURE <u>J. E. Benjigs (D.D.)</u> | | | | (Degree or title) | | 22b. ADDRESS <u>Wheatland, Mo.</u> | | 22c. DATE SIGNED <u>8-25-59</u> | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 23b. DATE <u>Aug 25, 1959</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Climax Springs Cemetery</u> | | 23d. LOCATION (City, town, or county) (State) <u>Climax Springs Benton Co. Mo</u> | | | | | | |
| 24. FUNERAL DIRECTOR <u>John J. Reser</u> | | | ADDRESS <u>Warsaw</u> | | 25. DATE RECD. BY LOCAL REG. <u>Aug 25-1959</u> | | 26. REGISTRAR'S SIGNATURE <u>Jas. A. Logans</u> | | | |

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by _____
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed John J. Reser

Licensed Embalmer No. 4098

P. O. Address Warsaw

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.